Grier Revised Consent Decree

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- 1979 - Daniels vs. White
- 1994 -TennCare
- 1999 - Grier Revised Consent Decree

Key Provisions

- Adequate notice
- Appeal rights
- Procedural protection
- Appeal filed within 30 days

Key Provisions

- 2 Types of appeals
  - Standard
  - Expedited
- Medical necessity denials
- Compliance requirements

Expedited Appeal

Time sensitive - care constitutes an "emergency"

- Serious health problems or death
- Serious dysfunction of a bodily organ or part
- Hospitalization

When Does Grier Apply?

An **Enrollee** experiences an **adverse action** regarding **TennCare benefits or services** (*medical assistance funded wholly or in part with federal funds under the Medicaid Act*) administered by TennCare through their managed care contractors (MCC)

Adverse Action

- Denial
- Delay
- Termination
- Suspension
- Reduction
- Any act, or failure to act that impacts the quality, availability, or timeliness of a Medicaid MR Waiver Service to an eligible person

When Grier does not apply

- State-funded services
- Person is on the waiting list -not enrolled to receive Medicaid services
- Services provided without PA
- Rate Issues

Provider Responsibilities

- Educate staff
- Provide adequate network
- Provide services as authorized
- Provide services consistently and timely

Provider Responsibilities

- Regional Office must be informed immediately upon any provider-initiated adverse action
- Failure may result in sanctions or recoupment of funds by DIDD

Provider-Initiated Adverse Actions

- The Regional Office must be informed a minimum of **60 days** before ceasing to provide services
- Services must continue until a new provider is located and approved

How to file an appeal

TennCare Medical Appeal Form

http://tennessee.gov/tenncare/forms/medappeal.pdf

Having problems getting health care or medicine in TennCare?

Use this page **only** to file a

TennCare Medical Appeal.

Need help filing a medical appeal?
- Call **1-800-878-3192** for free.

Versión en español atrás

Fill out **both** pages. These are **facts we must have to work your appeal.** If you don't tell us all the facts we need, we may not be able to decide your appeal. You may **not** get a fair hearing. Need help understanding what facts we need? Call us for free at **1-800-878-3192.** If you call, we can also take your **appeal by phone.**

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1. Who is the person that wants to appeal?

Full name _____ Date of birth___/___/____

Social Security Number_____-_____-_____ Or number on their TennCare card _____

Current mailing address_____

City_____ State _____ Zip Code_____

The name of the person we should call if we have questions about this appeal:_____

A daytime phone number for that person (____)_____-_____

2. Who filled out this form?

If **not** the person that wants to appeal, tell us your name._____

Are you a: ____ Parent, relative, or friend ____ Advocate or attorney ____ Doctor or health care provider

3. What is the appeal for? (Place an **X** beside the right answer below.)

___ Want to **change health plans.** (Fill out **Part A** on page 2.)

___ **Need care or medicine.** (Fill out **Part B** on page 2.)

___ Have **bills or paid for care or medicine** you think TennCare should pay. (Fill out **Part C** on page 2.)

4. Do you think you have an emergency?

Usually, your appeal is decided within **90 days** after you file it. But, **if you have an emergency,** you may not be able to wait 90 days. **An emergency means if you don't get the care or medicine sooner than 90 days:**

- You will be at risk of serious health problems or you may die.
- Or, it will cause serious problems with your heart, lungs, or other parts of your body.
- Or, you will need to go into the hospital.

Do you STILL think you have an emergency? If so, you can ask TennCare for an emergency appeal. **Your appeal may go faster if your doctor signs below saying that this appeal is an emergency.** What if your doctor **doesn't** sign below, but **you ask** for an emergency appeal? **TennCare will ask your doctor** if your appeal is an emergency. If **your doctor** says it's **not** an emergency, TennCare will decide your appeal within 90 days. Some kinds of care are **never** treated as an emergency. To get a list of those kinds of care, ask TennCare.

If YOU want to ask TennCare for an EMERGENCY APPEAL, check this box. ☐

Your DOCTOR can read and sign here to ask TennCare for an emergency appeal. I certify under penalty of perjury that I am the treating physician of the patient on behalf of whom this medical appeal is filed and that this appeal is an **emergency.** If this patient is required to wait 90 days for this care, s/he is at risk of serious health problems or death severe impairment of bodily organs or parts, or hospitalization. I understand that any intentional act on my part to provide false information is considered an act of fraud under the State's TennCare Program & Title XIX of the Social Security Act.

Physician Signature:_____ Date:_____

Tennessee License Number:_____

Keep reading. There is **1 more page** for you to fill out.

5. Tell us why you want to appeal this problem. Include any mistake you think TennCare made. And, send copies of any papers that you think may help us understand your problem.

_____

_____

_____

To see which Part(s) you should fill out below, look at number **3** on page 1.

Part A. Want to change health plans. Name of health plan you want _____

Part B. Need care or medicine. What kind - be specific _____

What's the problem?
___ Can't get the care or medicine at all.
___ Can't get as much of the care or medicine as I need.
___ The care or medicine is being cut or stopped.
___ Waiting too long to get the care or medicine.

Did your doctor prescribe the care or medicine? ___Yes ___No If yes, doctor's name_____

Have you asked your health plan for this care or medicine? ___Yes ___No If yes, when? _____

What did they say? _____

Did you get a letter about this problem? ___Yes ___No If yes, the date of the letter_____

Who was the letter from? _____

Are you getting this care or medicine from TennCare now? ___ Yes ___ No

Do you want to see if you can keep getting it during your appeal? ___ Yes ___ No

Does your doctor say you still need it? ___ Yes ___ No If yes, doctor's name _____

If you keep getting care or medicine during your appeal and you lose, you may have to pay TennCare back.

Part C. Bills for care or medicine you think TennCare should pay for

The date you got the care or medicine_____ Name of doctor, drug store, or other place that gave you the care or medicine _____ Their phone number (___)_____-_____

Their address _____

Did you **pay for the care or medicine and want to be paid back?** ___ Yes ___ No

If yes, you must send a copy of a **receipt** that proves you paid for the care or medicine.

If you didn't pay, **are you getting a bill?** ___ Yes ___ No If yes, and you think TennCare should pay, you must send a copy of a **bill.** Tell us the date you first got a bill (if you know). _____

How to file your medical appeal

Make a copy of the completed pages to keep.

Then, **mail** these pages and other facts to:

TennCare Solutions
P.O. Box 593
Nashville, TN 37202-0593

Or, **fax** it (toll-free) to 1-888-345-5575. **Keep a copy** of the page that shows your fax went through.

To appeal by **phone**, call 1-800-878-3192 for free.
Have speech or hearing problems? Call our TTY/TDD line for free at 1-866-771-7043.

Rev:08Feb10

We do not allow unfair treatment in TennCare.

No one is treated in a different way because of race, color, birthplace, language, sex, age, religion, or disability.
If you think you've been treated unfairly, call the Family Assistance Service Center for free at **1-866-311-4287.**

TennCare Appeal of Final ISP, Level of Need or Medical Care

Person Desiring to Appeal: _____ Date of Birth: _____

Social Security #: _____ Number on TennCare Card: _____

Current Mailing Address: _____

Name to Call Regarding the Appeal: _____

Daytime Phone #: _____

Person Completing this Form: _____

Relationship:

Parent, Relative, Conservator or Friend.
Advocate or Attorney
Provider Agency
ISC

What is Appeal For:

Services
Level of Need Determination
Medical Care or Medicine

Continuation of Services
If you were receiving the services, the level of need, or the medical care, and request continuation of the services, of the level of need, or of the medical care, within 10 days of notification of denial or delay, then the services, level of need, or the medical care, will continue to be provided during the pendency of the appeal.

Do you request continuation of services? _____ YES _____ NO

Do you have an emergency?
If you do not qualify for continuation of services, but you can not wait 90 days for services, level of need designation, or medical care, check here: _____

The enrollee's doctor can sign below certifying that the appeal is an emergency, and to wait 90 days would put the enrollee in serious risk of harm.

Physician: _____ Date: _____

Tennessee License Number: _____

MEDICAID WAIVER APPEAL

An appeal may be filed if a person's Medicaid Waiver services have been denied, terminated, reduced, delayed or are not being provided as needed. Anyone may submit an appeal on the person's behalf. You do not have to use this form to file an appeal. You may make your appeal in a letter or you may call in your appeal. The appeal must be made within 35 days of the date of the adverse action notice (letter) from the Division of Mental Retardation Services (DMRS). Below is the information that should be included in an appeal for Medicaid Waiver services.

1. THE PERSON ABOUT WHOM THIS APPEAL IS BEING FILED:

Full Name: _____ Today's Date: _____

Date of Birth: _____ Social Security Number: _____

Current Mailing Address: _____

City: _____ State: _____ Zip: _____

2. THE NAME OR TYPE OF SERVICE(S) BEING APPEALED:

_____

Note: If the DMRS denied, terminated, suspended, or reduced a service, you may request that the service be continued as currently authorized while the appeal is being considered and until a final decision is made by the TennCare Solutions Unit. To request a continuation, you must submit the appeal within 15 days of the date of the adverse action notice from the DMRS.

3. TO CONTINUE THE SERVICE UNTIL THE APPEAL IS DECIDED WRITE "YES" HERE:* Yes

(*This appeal must be submitted no later than 15 days from the date of the notice to ensure continuation of the service during appeal.)

4. THE PERSON WHO IS SUBMITTING THIS APPEAL:

Name: _____

Relationship: _____ Daytime Phone # _____

5. THE PERSON WHO CAN ANSWER QUESTIONS ABOUT THIS APPEAL:

(This is the person that the DMRS or TennCare should call for more information. Leave blank if same as the person submitting the appeal.)

Name: _____

Relationship: _____ Daytime Phone # _____

5. OTHER INFORMATION ABOUT WHY THIS APPEAL IS BEING FILED (Optional):

(If desired, you may state below the reasons for this appeal OR attach additional information. However, you may leave this section blank if you wish. You are not required to provide any additional information at time that you file the appeal. You will have a chance to provide more information about your appeal to the DMRS or TennCare after you file the appeal. Someone may call and ask you for more information about your appeal. If there is a hearing about your appeal, someone will contact you to schedule the hearing. During the hearing, you will have an opportunity to tell your reasons to administrative law judge.)

7. HOW TO FILE THIS APPEAL (with TennCare):

(You may fax, mail or call-in your appeal. The appeal goes to the Bureau of TennCare's Solutions Unit. TennCare Solutions handles all Medicaid Waiver and TennCare appeals. You may also send a copy to the Regional Office of the Division of Mental Retardation Services.)

Fax TennCare:	OR	Mail:	OR	Call TennCare:
1 – 888 – 345 – 5575		TennCare Solutions		1 – 800 – 878 – 3192
(Toll Free)		P.O. Box 000593		(Toll Free)
		Nashville, TN 37203 – 0593		

☐ Check here if also sent to DMRS Regional Office / Fax Number: _____

APPEAL OF DMRS MEDICAID WAIVER SERVICES

Name: (first, middle, last)

Social Security Number: Date of Birth:

Address:

City, State, Zip:

Name of Authorized Representative Filing Appeal:
(if other than person whose services were denied)

Signature of Person Filing Appeal:

Telephone Number: Relationship:

Support Coordinator: Phone:

Names of Anyone Who Should Be Contacted Regarding This Appeal:

Name: Phone:
Name: Phone:

What are you appealing? ☐ Denial ☐ Reduction ☐ Suspension ☐ Termination ☐ Delay
☐ Other

If you marked other, please explain:

What is the service that you are appealing?

Date of Circle of Support/Support Team meeting

Date that notice was received from DMR Regional Office

If this is a medical service, will it be dangerous for you to go without the service for very long? ☐ Yes ☐ No

Are you receiving this care through DMRS now? ☐ Yes [ ] No

Do you want to see if you can continue to receive this care during your appeal?
☐ Yes ☐ No

Explanation:

Withdrawing appeal:

- Person, ISC or Legal Representative
- If hearing not scheduled, must be in writing
- If hearing is scheduled, should be withdrawn through LSU

Debra Ball, Appeals Director, MTRO
(615) 884-6090

Lori Shelton, Appeals Director, ETRO
(865) 588-0508, ext. 239

Libby Taylor, Appeals Director, WTRO
(901) 745- 7327

Jon Hamrick, Director of Medicaid Affairs, CO
(615) 253-8734